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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1505 Session of 1997

INTRODUCED BY VEON, SURRA, THOMAS, GEORGE, BELARDI, SATHER, MUNDY, ROONEY, MANDERINO, WALKO, HALUSKA, McCALL, CAPPABIANCA, YOUNGBLOOD, CASORIO, BLAUM, CURRY, ITKIN, BEBKO-JONES, SHANER, MELIO, OLASZ, LAUGHLIN, DeLUCA, SCRIMENTI, PRESTON, JOSEPHS, MIHALICH, PETRARCA, BOSCOLA, WASHINGTON, GIGLIOTTI, STEELMAN, TRICH, A. H. WILLIAMS AND M. COHEN, MAY 14, 1997

REFERRED TO COMMITTEE ON INSURANCE, MAY 14, 1997

AN ACT

Amending the act of December 29, 1972 (P.L.1701, No.364), entitled "An act providing for the establishment of nonprofit corporations having the purpose of establishing, maintaining and operating a health service plan; providing for supervision and certain regulations by the Insurance Department and the Department of Health; giving the Insurance Commissioner and the Secretary of Health certain powers and duties; exempting the nonprofit corporations from certain taxes and providing penalties," further providing for definitions, for services to be provided and for certificates of authority; providing for managed care comparison reports; further providing for contracts with providers and insurers; providing for clinical quality assurance, for consumer and provider information, for a managed care consumer advocate program, for grievance procedures, for utilization review and for managed care organization standards for an availability and accessibility bill of rights; and making editorial changes.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Sections 1 and 2 of the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, amended December 19, 1980 (P.L.1300, No.234), are amended

to read:

Section 1. Short Title.--This act shall be known and may be cited as the ["Health Maintenance Organization] "Managed Care Plan Act."

Section 2. Purpose.--The purpose of this act is to permit and encourage the formation and regulation of [health maintenance organizations] managed care plans and to authorize the Secretary of Health to provide technical advice and assistance to corporations desiring to establish, operate and maintain [a health maintenance organization] managed care plans to the end that increased competition and consumer choice offered by diverse [health maintenance organizations] managed care plans can constructively serve to advance the purposes of quality assurance, cost-effectiveness and access.

Section 2. The definition of "direct provider" in section 3 of the act, amended December 19, 1980 (P.L.1300, No.234), is amended and the section is amended by adding definitions to read:

Section 3. Definitions.--As used in this act:

* * *

"Clinical peer" or "peer" means a physician or other health care professional who holds a nonrestricted license in this Commonwealth or another state and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

* * *

"Department" means the Department of Health of the Commonwealth.

"Direct provider" means an individual who is a direct provider of health care services under a benefit plan of a

[health maintenance organization] managed care plan or an individual whose primary current activity is the administration of health facilities in which such care is provided. An individual shall not be considered a direct provider of health care solely because the individual is a member of the governing body of a health-related organization.

"Direct services ratio" means the ratio between an organization's medical revenues and medical expenses.

"Emergency" means a medical emergency.

"Enrollee" or "subscriber" means a person covered by a health insurance policy or managed care plan including a person who is covered as an eligible dependent of another person.

"Grievance" means a complaint made by or on behalf of a subscriber. The term includes:

(1) a determination by a managed care plan or its designated utilization review organization or by any health care professional or health care facility affiliated with or acting under arrangement with the plan, that an admission, availability of care, continued stay or other health care service reviewed does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and that, the requested service is therefore denied, reduced or terminated;

(2) the availability, delivery or quality of health care services, including delay, timing or location of services, appropriate skill level of health care professional, denial of coverage for emergency and related services or any other managed care plan action or policy which hinders the receipt of covered health care services;

(3) claims payment, handling or reimbursement for health

care services; or

(4) matters pertaining to the contractual relationship between a covered person and a managed care plan.

* * *

"Health outcomes" means:

(1) the results of treatment adjusted for severity for patients seeking treatment;

(2) the recurrence of treatment; and

(3) the treatment received which is indicative of the possible lack of treatment of a less severe but related health problem.

"Managed care plan" or "plan" means a system pursuant to which health care, related equipment or services are provided for members or subscribers whose access to other health care must be approved by a primary care practitioner selected by or for such member or subscriber from a panel of participating practitioners. The term includes, but is not limited to, health maintenance organizations and preferred provider organizations.

"Medical audit" means an onsite review of the quality of care being provided and the effectiveness of the quality assurance of the managed care plan.

"Medical emergency" means the initial treatment of a sudden, unexpected onset of a medical condition or traumatic injury, but does not include treatment for an occupational injury for which benefits are provided under any workers' compensation law or occupational disease law. The symptoms or injury must be of sufficient severity that a prudent layperson would seek immediate attention.

"Medical expenses" means the cost of providing health care services.

"Medical revenues" means the income generated from providing health care services.

"Medically necessary" means treatment which is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Treatment is considered reasonable and necessary if it is safe, effective and appropriate. The term does not include experimental or investigational treatment.

"Preferred provider organization" means a health care benefit arrangement designed to supply services at a reasonable cost through incentives for enrollees to use designated health care providers and in which:

(1) patients pay more to use services rendered by health care providers who are not part of the organization's network; and

(2) health care providers expect to benefit through increased patient volume and prompt payment, in return for the health care providers' agreement to abide by a fee schedule and follow utilization management procedures.

"Primary care provider" means a health care professional who is designated by a managed care plan to supervise, coordinate, or provide initial care or continuing care to a subscriber, and who may be required by the plan to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the subscriber. The term includes a physician, a gynecologist, a pediatrician, an obstetrician or other licensed health care specialist.

"Risk-assuming preferred provider organization" means a preferred provider organization which has one or more of the following characteristics:

(1) Assumption by the preferred provider organization of financial risk arising out of contractual liability to pay for or reimburse enrollees for covered health care services.

(2) Participation in financial gains or losses of a health benefits plan based on aggregate measures of expenditures or utilization.

(3) Participation in the overall financial risk of a health benefits plan by placing upper limits on future premium increases.

(4) Other characteristics which create a financial risk to the preferred provider organization and arise out of the preferred provider arrangement.

The term does not include a third-party administrator, or a licensed insurer, when functioning solely as a third-party administrator.

* * *

Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb or permanent health of the injured or ill person, without regard to where these services are provided, and that may include services provided out of a managed care plan's approved service area pursuant to indemnity payments or plan contracts.

Section 3. Sections 4 and 5.1 of the act, amended or added December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 4. Services Which Shall be Provided.--(a) Any law to the contrary notwithstanding, any corporation may establish, maintain and operate a [health maintenance organization] managed care plan upon receipt of a certificate of authority to do so in

accordance with this act.

(b) Such [health maintenance organizations] managed care plans shall:

(1) Provide either directly or through arrangements with others, basic health services to individuals enrolled;

(2) Provide either directly or through arrangements with other persons, corporations, institutions, associations or entities, basic health services; [and]

(3) Provide physicians' services (i) directly through physicians who are employes of such organization, (ii) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis or (iii) under similar arrangements which are found by the secretary to provide adequate financial incentives for the provision of quality and cost-effective care.

Section 5.1. Certificate of Authority.--(a) Every application for a certificate of authority under this act shall be made to the commissioner and secretary in writing and shall be in such form and contain such information as the regulations of the Departments of Insurance and Health may require.

(b) A certificate of authority shall be jointly issued by order of the commissioner and secretary when:

(1) The secretary has found and determined that the applicant:

(i) has demonstrated the potential ability to assure both availability and accessibility of adequate personnel and

facilities in a manner [enhancing] assuring availability, accessibility, quality of care and continuity of services in accordance with section 10.1 of this act;

(ii) has [arrangements for an ongoing quality of health care assurance program; and] demonstrated, to the satisfaction of the secretary, that its internal quality assurance system can identify, evaluate and remedy problems relating to access, continuity, underutilization and quality of care in accordance with section 9.1 of this act;

(iii) has appropriate mechanisms whereby the [health maintenance organization] managed care plan will effectively provide or arrange for the provision of basic health care services on a prepaid basis; [and]

(iv) has demonstrated that one-sixth of the board membership represents front line employes of the plan or their union representatives and that one-third of the board membership represents enrollees who were elected by the enrollees of the plan; and

(v) has demonstrated compliance with the provisions of this act.

(2) The commissioner has found and determined that the applicant has a reasonable plan to operate the [health maintenance organization] managed care plan in a financially sound manner and is reasonably expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner [may] shall consider:

(i) The adequacy of working capital and funding sources.

(ii) Arrangements for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of

discontinuance of the [health maintenance organization] managed care plan.

(iii) Any agreement with providers of health care services whereby they assume financial risk for the provision of services to subscribers.

(iv) Any deposit of cash, or guaranty or maintenance or minimum restricted reserves which the commissioner, by regulation, may adopt to assure that the obligations to subscribers will be performed.

(v) That no managed care plan shall possess a direct services ratio less than ninety per cent during the prior three-year licensing period.

(c) Within ninety days of receipt of a completed application for a certificate of authority, the commissioner and secretary shall jointly either:

(1) approve the application and issue a certificate of authority; or

(2) disapprove the application [specifying] and specify in writing the reasons for such disapproval. Any disapproval of an application may be appealed in accordance with Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

(d) A certificate of authority shall expire three years from the date of issuance.

Section 4. The act is amended by adding a section to read:

Section 5.2. Managed Care Comparison Reports.--(a) Pursuant to the act of July 8, 1986 (P.L.408, No.89), known as the "Health Care Cost Containment Act," the council shall, on an annual basis, publish managed care comparison reports. The reports shall measure and compare the cost effectiveness and

quality of service of each managed care plan operating in this Commonwealth.

(b) Each managed care plan shall report to the council the following:

(1) Outcomes for conditions identified by the council.

(2) The direct services ratio.

(3) The number of members per 1,000 seeking and receiving treatment for conditions identified by the council.

(4) Other information requested by the council consistent with subsection (a) of this section.

(c) The council shall develop standardized reporting requirements and procedures to implement this section.

(d) The council shall develop subscriber and provider satisfaction surveys in accordance with written survey protocols developed by the council to survey at least annually a broad range of current subscribers, former subscribers, direct providers and primary care providers of each certified managed care plan. Surveys shall be returned to the council by subscribers, direct providers and primary care providers in postage-paid envelopes for processing. The council shall report the results to the department and to the plan. The results shall be included in the comparison reports.

(e) Each managed care plan shall provide its subscribers with a current copy of its annual comparison report.

Section 5. Sections 6.1, 7, 8 and 9 of the act, amended or added December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 6.1. Foreign [Health Maintenance Organizations] Managed Care Plans.--(a) A [health maintenance organization] managed care plan approved and regulated under the laws of another state may be authorized by issuance of a certificate of

authority to operate or do business in this Commonwealth by satisfying the commissioner and the secretary that it is fully and legally organized under the laws of [its] the other state, and that it complies with all requirements for [health maintenance organizations] managed care plans organized within the Commonwealth.

(b) The commissioner and the secretary may waive or modify the provisions of this act under which they have the authority to act if they determine that the same are not appropriate to a particular [health maintenance organization] managed care plan of another state, that such waiver or modification will be consistent with the purposes and provisions of this act, and that it will not result in unfair discrimination in favor of the [health maintenance organization] managed care plan of another state.

(c) The commissioner and the secretary are hereby authorized and directed to develop with other states reciprocal licensing agreements concerning the licensure of [health maintenance organizations] managed care plans which permit the commissioner and the secretary to accept audits, inspections and reviews of agencies from other states to determine whether [health maintenance organizations] managed care plans licensed in other states meet Commonwealth requirements.

Section 7. Board of Directors.--A corporation receiving a certificate of authority to operate a [health maintenance organization] managed care plan under the provisions of this act shall be organized in such a manner that assures that at least one-third of the membership of the board of directors of the [health maintenance organization] managed care plan will be subscribers of the [organization] plan. The board of directors

shall be elected in the manner stated in the corporation's charter or bylaws.

Section 8. Contracts with Practitioners, Hospitals, Insurance Companies, Enrollees, Etc.--(a) Contracts enabling [the] a corporation to provide the services authorized under section 4 of this act made with hospitals and practitioners of medical, dental and related services shall be filed with the secretary. The secretary shall have power to require immediate renegotiation of such contracts whenever he determines that they provide for excessive payments, or that they fail to include reasonable incentives for cost control, or that they otherwise substantially and unreasonably contribute to escalation of the costs of providing health care services to subscribers, or that they are otherwise inconsistent with the purposes of this act.

(b) A [health maintenance organization] managed care plan may reasonably contract with any individual, partnership, association, corporation or organization for the performance on its behalf of other necessary functions including, but not limited to, marketing, enrollment, and administration, and may contract with an insurance company authorized to do an accident and health business in this State or a hospital plan corporation or a professional health service corporation for the provision of insurance or indemnity or reimbursement against the cost of health care services provided by the [health maintenance organization] managed care plan as it deems to be necessary. Such contracts shall be filed with the commissioner.

(c) A managed care plan may not discourage or prevent a primary care provider, through a contractual arrangement or otherwise, from discussing any diagnostic or treatment option.

(d) (1) Notwithstanding the provisions of any law to the

contrary, if a managed care plan terminates its contract with a participating provider at the plan's initiative, an enrollee who has selected that provider to receive covered services may continue to receive covered services from that provider, at the enrollee's option, until the end of the enrollee's period of enrollment or for up to one year of treatment, whichever date is later. During that period, those health care services shall be covered by the plan under the same terms and conditions as they were covered while the provider was participating in the plan.

(2) A managed care plan shall require all providers upon entering into or renewing contracts with the plan to agree to continue to provide health care services to an enrollee of the plan under the same terms and conditions as stipulated in the contract for a period of up to one year following termination of the contract. Exceptions to this subsection shall be made if the provider relocates outside the service area.

(e) No managed care plan may provide any financial incentive in an effort to influence treatment decisions.

Section 9. Right to Serve or Benefits When Outside the State.--If a subscriber entitled to services provided by the corporation necessarily incurs expenses for such services while outside the service area, the [health maintenance organization] managed care plan to which the person is a subscriber may, in its discretion and if satisfied both as to the necessity for such services and that it was such as the subscriber would have been entitled to under similar circumstances in the service area, reimburse the subscriber or pay on his behalf all or part of the reasonable expenses incurred for such services. Such decision for reimbursement shall be subject to review by the commissioner at the request of a subscriber.

Section 6. The act is amended by adding sections to read:

Section 9.1. Clinical Quality Assurance.--(a) Each managed care plan shall develop a clinical quality assurance plan for the monitoring and evaluation of health care provided by all participating providers of the managed care plan.

(b) The quality assurance plan shall be submitted to and approved by the department prior to the managed care plan's enrolling subscribers. Certified plans shall submit a quality assurance plan within six months of the effective date of this section, and annually thereafter, for review and approval by the department.

(c) The quality assurance plan shall be available at no cost to the general public.

(d) The quality assurance plan shall include:

(1) An identifiable structure for performing quality assurance functions within the managed care plan, including regular meetings and records of meetings.

(2) Quality assurance objectives which include specific goals for implementation.

(3) A system for physician and other health professional performance review.

(4) A method for assuring a comprehensive review.

(5) A system for evaluating health outcomes, including, but not limited to, outcomes for persons with disabilities, chronic illnesses, rare diseases, mental illnesses and substance abuse problems.

(6) Written guidelines for quality of care studies and related monitoring activities.

(7) Quality indicators relating to specific clinical or health service delivery areas which are objective, measurable

and based on current knowledge and clinical experience.

(8) Health services delivery standards or practice guidelines consistent with standards and guidelines developed by commonly accepted sources and approved by the department.

(9) A method for evaluating and monitoring individual cases.

(10) A provision for periodic medical audits at least every two years by the department.

(11) An internal grievance system.

(12) Procedures for suspending or terminating participating providers for providing substandard care under the benefit plan of the managed care plan.

(13) A provision requiring the submission of annual reports to the department.

(14) A system for protecting and promoting subscriber rights.

(15) A system for assuring compliance with medical records standards and continuous confidentiality of medical records.

(16) A system for credentialing and recredentialing participating providers every three years.

(17) A provision authorizing the release of all standards used for coverage decisions with participating providers to the department and the subscribers.

(18) A system to insure that any denial of coverage is approved by a provider specializing in the condition for which treatment is sought.

(19) The managed care plan's direct services ratio for the most recent quarter.

(20) A system to establish discharge planning standards for subscribers about to be released from State mental hospitals or correctional facilities.

Section 9.2. Release of Information.--(a) Each managed care plan shall develop common language informational materials for subscribers and prospective subscribers to include:

(1) Benefits provided under the contract and any benefit limitations, exclusions, prior authorization requirements, standing referral procedures and procedures or services the managed care plan has designated experimental or investigational.

(2) An explanation of the procedure for selecting, changing and accessing participating providers, including:

(i) the subscriber's financial responsibility for services provided under the benefit plan; and

(ii) a description of how to obtain all necessary authorizations and price authorization requirements.

(3) A summary of minimum standards for continuity, access and availability of health care services, time between making an appointment and being seen in accordance with section 16.1 and how the managed care plan complies with those requirements.

(4) An explanation of policies, procedures and other criteria that form the basis for a denial or limitation of coverage or reimbursement.

(5) A current list of all providers, primary care providers and specialists available to subscribers, including, but not limited to, any limitation on their availability, address, specialty and hospital affiliation.

(6) A description of the managed care plan's method of resolving subscriber complaints, including claim or treatment denials, dissatisfaction with care and access to care and a description of any other complaint and appeal rights in accordance with section 9.4 of this act.

(7) How to contact the department's consumer advocate and a description of services provided by the consumer advocate.

(8) A card stating the toll-free telephone number for a subscriber or a health care provider to contact the plan to receive authorizations.

(9) A description of the mechanisms in which subscribers may participate in the development of policies of the plan.

(10) A description of practice standards or parameters which deviate from the practice standards or parameters established or recognized by a professional provider association.

(b) The managed care plan shall advise participating providers of:

(1) Practice standards and parameters used by the plan in approving and paying for services.

(2) Practice standards and parameters which deviate from the practice standards and parameters established or recognized by a professional provider association.

The information required by this subsection shall be updated at least annually and any time that the information is altered.

Section 9.3. Managed Care Consumer Advocate Program.--(a) A managed care consumer advocate program shall be established within the department to perform the following functions on behalf of enrollees of managed care plans:

(1) Assist consumers in receiving a timely response from managed care plan representatives.

(2) Assist consumers by providing information, referral and assistance to individuals about means of obtaining health coverage and services appropriate to the consumers' needs.

(3) Educate and train consumers in the use of available resources concerning managed care plans.

(4) Assist enrollees to understand their rights and responsibilities under their managed care plan. This clause includes accessing appropriate levels of care and specialty providers.

(5) Identify, investigate and resolve enrollee complaints about health care services and assist enrollees with filing complaints and appeals.

(6) Advocate policies and programs that protect consumer interests and rights under managed care plans.

(7) Prepare an annual consumer satisfaction survey for distribution to the public.

(b) The consumer advocate shall be accessible through a toll-free telephone number and shall ensure that individuals receive timely responses to their inquiries.

(c) The consumer advocate shall be immune from civil liability for good faith performance of official duties.

(d) Each managed care plan shall advise enrollees of the role of the consumer advocate and how to contact the consumer advocate.

(e) The consumer advocate shall report to the General Assembly on the types of assistance, provided by category and frequency of assistance provided by each managed care plan.

Section 9.4. Grievance Procedure.--(a) A managed care plan shall possess a written grievance procedure for prompt and effective resolution of enrollee grievances approved by the secretary. Any modifications to the grievance procedure shall be approved by the secretary. The grievance procedure shall include the following elements:

(1) There shall be a uniform standard for initiating complaints.

(2) There shall be two levels of review with the second-level review being conducted by clinical peers assigned by the secretary.

(3) There shall be expedited reviews in cases of denials which may jeopardize the life or health of an enrollee with a maximum time period of five days or as rapidly as the situation requires, whichever is shorter, from the expedited review request.

(4) The enrollee shall be notified of the enrollee's rights at each step in the grievance process, which rights shall include:

(i) The right to appeal and the procedure to appeal.

(ii) The right to present pertinent data including testimony of expert witnesses.

(iii) The right to receive a written decision containing a summary of the grievance, the decision, the contract basis or medical rationale for the decision and the names and titles of the persons participating in the decision.

(iv) The continuation of health care services without being financially liable beyond the level required prior to the grievance for services received pending resolution of the second-level review.

(v) The right to contact and the toll-free telephone number of the consumer advocate.

(5) First-level review shall be completed within five working days from the date of the request, for expedited reviews.

(6) The parties involved in the grievance process shall cooperate in providing materials relevant to the grievance in a manner to permit a decision in accordance with the time periods

established in this act. Any delay in a decision that occurs as a result of the plan's actions or inactions shall result in a favorable decision for the enrollee.

(7) If the enrollee prevails at the second-level review or upon appeal to the department, the plan shall pay the enrollee's reasonable attorney fees, expert witness fees and other reasonable costs.

(8) The plan shall prepare and submit an annual report to the department regarding the volume of grievances for classifications of grievances designated by the advocate, the resulting decisions and the level at which the grievance was finally resolved.

(b) The secretary shall establish a managed care grievance procedure which shall include the following elements:

(1) There shall be review and approval of plan grievance procedures based on compliance with the requirements of this act, as well as other statutory or regulatory requirements.

(2) Clinical peers shall be randomly assigned, independent from the plan and shall have no financial interest in the grievance being processed at the second-level review.

(3) Second-level reviews shall be completed within thirty days of the request.

(4) An enrollee may request an appeal following a second-level review. The appeal shall be in the form of an administrative hearing pursuant to 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(c) Nothing in this act shall be construed to preempt other consumer rights or remedies available under law.

Section 9.5. Oversight of Utilization Review Program.--A managed care plan shall monitor all utilization review

activities carried out by, or on behalf of, the plan and for ensuring that all requirements of this act and applicable regulations are satisfied. The plan shall also ensure that appropriate personnel have operational responsibility for the conduct of the plan's utilization review program.

Section 9.6. Contracting.--If a managed care plan contracts for a utilization review organization or other entity to perform the utilization review functions required under this act or applicable regulations, the secretary shall hold the plan responsible for monitoring the activities of the utilization review organization or entity with which the plan contracts and for ensuring that the requirements of this act and applicable regulations are satisfied.

Section 9.7. Utilization Review.--(a) A managed care plan that conducts utilization review shall implement a written utilization review program that describes all review activities, both delegated and nondelegated, for covered services provided. The program document shall describe the following:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy or efficiency of health services.

(2) Data sources and clinical review criteria used in decision making.

(3) The process for conducting appeals of adverse determinations.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and proprietary information.

(7) The organizational structure, such as utilization review committee, quality assurance or other committee, that periodically assesses utilization review activities and reports to the plan's governing body.

(8) The staff position functionally responsible for day-to-day program management.

(b) A managed care plan shall file an annual summary report of its utilization review program activities with the department.

Section 9.8. Operational Requirements.--(a) A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A managed care plan may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. A managed care plan shall make available its clinical review criteria to the department.

(b) Qualified health care professionals shall administer the utilization review program and oversee review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

(c) A managed care plan shall issue utilization review decisions in a timely manner and as follows:

(1) The plan shall obtain all information required to make a utilization review decision, including pertinent clinical information.

(2) The plan shall develop and implement a process to ensure that utilization reviewers apply clinical review criteria consistently.

(d) A managed care plan shall routinely assess the

effectiveness and efficiency of its utilization review program.

(e) A managed care plan's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the plan to monitor and manage health care services effectively.

(f) If a managed care plan delegates any utilization review activities to a utilization review organization, the plan shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the utilization review organization program by the plan.

(3) A process by which the plan evaluates the performance of the utilization review organization.

(g) A managed care plan shall coordinate the utilization review program with other medical management activity conducted by the plan, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction and risk management.

(h) A managed care plan shall provide covered persons and participating providers with access to its review staff by a toll-free telephone number.

(i) When conducting utilization review, a managed care plan shall collect only information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services.

(j) No compensation to persons providing utilization review services for a managed care plan shall contain incentives, direct or indirect, for those persons to make inappropriate

review decisions. No compensation to those persons may be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Section 9.9. Procedures for Review Decisions.--(a) A managed care plan shall maintain written procedures for making utilization review decisions and for notifying subscribers and providers acting on behalf of subscribers of its decisions.

(b) (1) For initial determinations, a managed care plan shall issue the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, the term "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(2) In the case of a determination to certify an admission, procedure or service, the plan shall notify the provider rendering the service by telephone within twenty-four hours of making the initial certification and shall provide written or electronic confirmation of the telephone notification to the subscriber and the provider within two working days of the initial certification.

(3) In the case of an adverse determination, the plan shall notify the provider rendering the service by telephone within twenty-four hours of the adverse determination and shall provide written or electronic confirmation of the telephone notification to the subscriber and the provider within one working day of the adverse determination.

(c) (1) For concurrent review determination, a managed care plan shall issue the determination within one working day of obtaining all necessary information.

(2) In the case of a determination to certify an extended stay or additional services, the plan shall notify by telephone the provider rendering the service within one working day of the certification and shall provide written or electronic confirmation to the subscriber and the provider within one working day after the telephone notification. Written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

(3) In the case of an adverse determination, the plan shall notify by telephone the provider rendering the service within twenty-four hours of making the adverse determination and shall provide written or electronic notification to the subscriber and the provider within one working day of the telephone notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

(d) (1) For retrospective review determinations, a managed care plan shall make the determination within thirty working days of receiving all necessary information.

(2) In the case of a certification, the plan shall notify in writing the subscriber and the provider rendering the service.

(3) In the case of an adverse determination, the plan shall notify in writing the provider rendering the service and the subscriber within five working days of the adverse determination.

(e) A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating a grievance and the instructions for requesting a written statement of the clinical rationale,

including the clinical review criteria used to make the determination. A managed care plan shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures for a request.

(f) A managed care plan shall develop and implement written procedures to address the failure or inability of a provider or a subscriber to provide all necessary information for review. In cases where the provider or a subscriber will not release necessary information, the plan may deny certification.

Section 7. Section 10 of the act, amended December 19, 1980 (P.L.1300, No.234), is amended to read:

Section 10. Supervision.--(a) Except as otherwise provided in this act, a [health maintenance organization] managed care plan operating under the provisions of this act shall not be subject to the laws of this State now in force relating to insurance corporations engaged in the business of insurance nor to any law hereafter enacted relating to the business of insurance unless such law specifically and in exact terms applies to such [health maintenance organization] plan. For a [health maintenance organization] managed care plan established, operated and maintained by a corporation, this exemption shall apply only to the operations and subscribers of the [health maintenance organization] plan.

(b) All [health maintenance organizations] managed care plans shall be subject to the following insurance laws:

(1) The act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."

(2) Any rehabilitation, liquidation or conservation of a

[health maintenance organization] managed care plan shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies.

(c) (1) All rates charged subscribers or groups of subscribers by a [health maintenance organization] managed care plan and the form and content of all contracts between a [health maintenance organization] plan and its subscribers or groups of subscribers, all rates of payment to hospitals made by a [health maintenance organization] plan pursuant to contracts provided for in this act, budgeted acquisition costs in connection with the solicitation of subscribers, and the certificates issued by a [health maintenance organization] plan representing its agreements with subscribers shall, at all times, be on file with the commissioner and be deemed approved unless explicitly rejected within sixty days of filing.

(2) Filings under this subsection shall be [made] submitted to the commissioner in such form, and shall set forth such information as the commissioner may require to carry out the provisions of this act. Any disapproval of a filing by the commissioner may be appealed in accordance with Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

(d) Solicitors or agents compensated directly or indirectly by any corporation subject to the provisions of this act shall meet such prerequisites as the commissioner by regulation shall require.

(e) A [health maintenance organization] managed care plan

shall establish and maintain a grievance resolution system satisfactory to the secretary, whereby the complaints of its subscribers may be acted upon promptly and satisfactorily.

(f) If a [health maintenance organization] managed care plan offers eye care which is within the scope of the practice of optometry, it shall make optometric care available to its subscribers, and shall make the same reimbursement whether the service is provided by an optometrist or a physician.

Section 8. The act is amended by adding sections to read:

Section 10.1. Availability and Accessibility Bill of Rights.--(a) A managed care plan shall cover health emergency services and urgent care services without authorization, regardless of provider or facility.

(b) A managed care plan shall include a sufficient number and type of primary care practioners, specialists and hospitals throughout the services area to meet the needs of enrollees and to ensure reasonable choice. The mix of providers shall meet the needs of enrollee population adjusted for characteristics including, but not limited to, age, gender and health status. At a minimum, the plan shall have one full-time primary care physician per 1,200 enrollees.

(c) A managed care plan shall permit subscribers to change primary care providers at any time upon notice to the plan. The plan may not require more than fifteen days' prior notice.

(d) A managed care plan shall develop and implement a procedure for subscribers with specific conditions to receive a standing referral from their primary care provider to a specialist with expertise in treating the condition. A standing referral may be authorized by the primary care provider if the subscriber requires continuing care from a specialist or if the

subscriber is suffering from a prolonged, life-threatening, degenerative or disabling condition. Authorization of the specialist to provide health care services to the subscriber shall be made in the same manner as the authorization of subscribers' primary care provider.

(e) No managed care plan may:

(1) Deny enrollment to a subscriber who is a member of a group for which the plan is providing or has proposed to provide basic health services.

(2) Offer to provide basic health services contingent upon the exclusion of individuals who would otherwise be included in the defined group.

(f) A managed care plan may not impose a penalty on enrollees who seek direct access to an obstetrician or gynecologist.

(g) In applying practice standards or parameters, a managed care plan shall make appropriate adjustments based on the severity of the subscriber's condition consistent with generally recognized standards or parameters established or recognized by a professional provider association.

(h) A managed care plan shall cover medically necessary services provided by any provider if a participating provider cannot attend to the enrollee within a time period appropriate to the enrollee's medical condition. In no case shall the waiting period for an appointment exceed thirty days from the date of initial contact to schedule an appointment.

(i) A managed care plan shall provide coverage for all FDA-approved drugs and devices, whether or not the drug or device has been approved for the specific treatment or condition, and provided that the treating physician determines that the drug or

device is medically necessary or appropriate for the enrollee's condition.

(j) Enrollees shall have thirty days from the commencement of the contract to cancel for any reason. Cancellation shall be provided to the managed care plan in writing, and a United States postmark shall be conclusive evidence of the date received.

(k) A managed care plan shall cover medically necessary services furnished as a result of a medical emergency by a nonparticipating provider.

(l) Enrollees shall be covered for any condition which is normally covered under the plan. This shall include secondary conditions resulting from a noncovered primary condition.

Section 10.2 Disenrollment Parameters.---(a) A managed care plan may disenroll an enrollee only in accordance with the following:

(1) A subscriber shall be provided a notice thirty days prior to disenrollment. The notice shall state the reason for the disenrollment, the effective date of disenrollment and the subscriber's right to appeal the disenrollment to the department.

(2) A disenrollment shall only be provided for nonpayment of charges or premiums, termination of conditions under which enrollment occurred, violation of policies published by the secretary, policies of the managed care organization as approved by the secretary, change of residence or fraudulent use of managed care services.

(3) The plan shall offer to each subscriber who is eligible for disenrollment, as a result of discontinuation of membership in a group enrolled with the managed care organization, a

subscription agreement with the same level of benefits as provided under the group contract. The plan may charge a different reasonable premium to any subscriber who is not a member of a group.

Section 9. Sections 11, 12, 13, 15, 16 and 17 of the act, amended December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 11. Reports and Examinations.--(a) (1) [The] A corporation that has a certificate of authority under section 4 of this act shall, on or before the first of March of every year, file with the commissioner a statement verified by at least two of the principal officers of the corporation summarizing its financial activities during the calendar or fiscal year immediately preceding, and showing its financial condition at the close of business on December 31 of that year, or the corporation's fiscal year. [Such] The statement shall be in such form and shall contain such matter as the commissioner prescribes.

(2) The financial affairs and status of [every such corporation] each corporation that has a certificate of authority under section 4 of this act shall be examined by the commissioner or [his] the commissioner's agents not less frequently than once in every three years [and for]. For this purpose, the commissioner and [his] the commissioner's agents shall be entitled to:

(i) the aid and cooperation of the officers and employes of the corporation [and shall have convenient];

(ii) access to all books, records, papers, and documents that relate to the financial affairs of the corporation[. They shall have authority to]; and

(iii) examine under oath or affirmation the officers, agents, employes and subscribers for the health services of the corporation, and all other persons having or having had substantial part in the work of the corporation in relation to its affairs, transactions and financial condition.

(3) The [Insurance Commissioner] commissioner may at any time, without making such examination, call on any such corporation for a written report authenticated by at least two of its principal officers concerning the financial affairs and status of the corporation.

(b) A corporation that has a certificate of authority under section 4 of this act shall maintain its financial records in such manner that the revenues and expenses associated with the establishment, maintenance and operation of its prepaid health care delivery system under this act are identifiable and distinct from other activities it may engage in which are not directly related to the establishment, maintenance and operation of its prepaid health care delivery system under this act.

(c) The secretary or [his] the secretary's agents shall have free access to all the books, records, papers and documents that relate to the business of the corporation, other than financial.

Section 12. Contracts to Provide Medical Care.--A [health maintenance organization] managed care plan established pursuant to this act may receive and accept from governmental or private agencies payments covering all or part of the cost of subscriptions to provide its services, facilities, appliances, medicines or supplies.

Section 13. Exemption from Taxation.--Every [health maintenance organization] managed care plan established, maintained and operated by a corporation not-for-profit is

hereby declared to be a charitable and benevolent institution and all its income, funds, investments and property shall be exempt from all taxation of the State or its political subdivisions.

Section 15. Penalty.--(a) The commissioner and secretary may suspend or revoke any certificate of authority issued to a [health maintenance organization] managed care plan under this act, or, in their discretion, impose a penalty of not more than one thousand dollars ($1,000) for each and every unlawful act committed, if they find that any of the following conditions exist:

(1) that the [health maintenance organization] managed care plan is providing inadequate or poor quality care, thereby creating a threat to the health and safety of its subscribers;

(2) that the [health maintenance organization] managed care plan is unable to fulfill its contractual obligations to its subscribers;

(3) that the [health maintenance organization] managed care plan or any person on its behalf has advertised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner; or

(4) that the [health maintenance organization] managed care plan has otherwise failed to substantially comply with this act.

(b) Before the commissioner or secretary, whichever is appropriate, shall take any action as above set forth, [he] the commissioner or secretary shall give written notice to the [health maintenance organization,] managed care plan accused of violating the law, stating specifically the nature of [such] the alleged violation and fixing a time and place, at least ten days thereafter, when a hearing of the matter shall be held. Hearing

procedure and appeals from decisions of the commissioner or secretary shall be as provided in Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

Section 16. Exclusions.--[Certificates] No certificates of authority shall [not] be required of:

(1) [Health maintenance organizations] Managed care plans offered by employers for the exclusive enrollment of their own employes, or by unions for the sole use of their members.

(2) Any plan, program or service offered by an employer for the prevention of disease among his employes.

Section 17. Effect of Act on Other Plans.--(a) Any requirements or privileges granted under this act shall apply exclusively to that portion of business or activities which reasonably relates to the establishment, maintenance and operation of a [health maintenance organization] managed care plan pursuant to the provisions of this act.

(b) [Any health maintenance organization program] A managed care plan approved by the commissioner or secretary and operating under the provisions of 40 Pa.C.S. Ch.61 (relating to hospital plan corporations) or 40 Pa.C.S. Ch.63 (relating to professional health services plan corporations) or under any statute superseded by either of such statutes, prior to the effective date of this act, may continue to operate under the provisions of such authority or successor provisions, if any.

Section 10. This act shall take effect in 60 days.